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		State Mandate Applicability		Small Employer Plans			Commercial HMO	State Employee Plans			Federal Employee Plans		
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	Federal Benefit Categories and State Mandates			345,781	83,532	181,105	153,588	440,104	270,490[3]	180,299	Not available	Not available	Not available
	Estimated cost to the state in 2014 and 2015, without Medicaid expansion[4]			*$0*	*$0*	*$0*	*$0*	$49.7M - $116.6 M	$46.6 M - $85.9 M	$49.7M - $116.6 M	$70.5M - $180.6M	$70.5M - $180.6M	$70.5M - $180.6M
Federal	**(A) Ambulatory Patient Services**												
Federal	Primary care visit to treat an injury or illness			√	√	√	√	√	√	√	√	√	√
Federal	Specialist visit			√	√	√	√	√	√	√	√	√	√
Federal	Other practitioner office visit (nurse, physician assistant)			√	√	√	√	√	√	√	√	√	√
Federal	Outpatient facility fee (e.g., ambulatory surgery center)			√	√	√	√	√	√	√	√	√	√
Federal	Outpatient surgery physician/surgical services			√	√	√	√	√	√	√	√	√	√
Federal	Home health care services			√[5] 60 visits	√[5] 60 visits	√[5] 60 visits	√[5] 60 visits	√ No limit	√[5] 60 visits	√[6] 120 visits	√[7] 25 visits	√[7] 25 visits	√[8] 50 visit
Federal	Skilled nursing facility			√[7] 25 days	√[7] 25 days	√[5] 60 days	√[5] 60 days	√[5] 60 days	√[7] 25 days	√[9] 180 days			√[10] 14 days
Federal	Hospice services			√	√	√	√	√[11]	√	√	√	√	√[12]
TX	***Home Health***	No	Offer	√	√	√	√	√	√	√	√	√	√
TX	**Transplant Donor Coverage**	Yes	No	√	√	√	√	√	√	√	√	√	√
Federal	**(B) Emergency Services**												
Federal	Emergency room services			√	√	√	√	√	√	√	√	√	√
Federal	Emergency transportation / ambulance			√	√	√	√	√	√	√	√	√	√
Federal	Urgent care centers or facilities			√	√	√	√	√	√	√	√	√	√
TX	**Emergency Care**	Yes	Yes	√	√	√	√	√	√	√	√	√	√
Federal	**(C) Hospitalization**												
Federal	Inpatient hospital services (e.g., hospital stay)			√	√	√	√	√	√	√	√	√	√
Federal	Inpatient physician and surgical services			√	√	√	√	√	√	√	√	√	√
TX	**Mastectomy or Lymph Node Dissection, Minimum Stay**	Yes	No	√	√	√	√	√	√	√	√	√	√
TX	**Mastectomy, Reconstructive Surgery**	Yes	Yes	√	√	√	√	√	√	√	√	√	√

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Federal	**(D) Maternity and newborn Care**												
	Prenatal and postnatal care			√	√	√	√	√	√	√	√	√	√
	Delivery and all inpatient services for maternity care			√	√	√	√	√	√	√	√	√	√
TX	**Maternity Minimum Stay (if maternity is covered)**	Yes	Yes	√	√	√	√	√	√	√	√	√	√
	Pregnancy	Offer	No	√	√	√	√	√	√	√	√	√	√
	Pregnancy, Complications	Yes	Yes	√	√	√	√	√	√	√	√	√	√
	Women's Health - In Vitro Fertilization	No	Offer	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Federal	**(E) Mental health and substance use disorder services, including behavioral health treatment**												
	Mental / behavioral health outpatient services			√[7] 25 visits	√[7] 25 visits	√[13, 14] 20 visits	√	√[15] 30 visits	√	√[16] 20 visits	√	√	√
	Mental / behavioral health inpatient services			√[17] 10 days	√[17] 10 days	√[18, 14] 15 days	√	√[15] 30 days	√	√[15] 30 days	√	√	√
	Substance abuse disorder outpatient services			√[20]	√[20]	√[13, 20] 20 visits	√	√	√	√[19, 20] 20 visits	√	√	√
	Substance abuse disorder inpatient services			√[20]	√[20]	√[18, 20] 15 days	√	√	√	√[21, 20] 30 days	√	√	√
TX	**Chemical Dependency – Benefits**	No	Yes	√	√	√	√	√	√	√	√	√	√
	Chemical Dependency - Treatment Facility	No	Yes	√	√	√	√	√	√	√	√	√	√
	Mental Illness - Psychiatric Day Treatment Facility	No	Offer	√	√	√	√	√	√	√	√	√	√
	Mental Illness - Crisis Stabilization & Residential Treatment for Children and Adolescents	No	Yes	√	√	√	√	√	√	√	*$0.7 M - $7.2 M*	*$0.7 M - $7.2 M*	*$0.7 M - $7.2 M*
	Mental Illness - Serious Mental Illness	No	Offer	√	√	*$0*	√	√	√	√	√	√	√
	Psychological Testing[22]			√	√	√		√	√	√	√	√	√

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Federal	**(F) Prescription Drugs**												
Federal	Generic drugs			√	√	√	√	√	√	√	√	√	√
Federal	Preferred brand drugs			√	√	√	√	√	√	√	√	√	√
Federal	Non-preferred brand drugs			√	√	√	√	√	√	√	√	√	√
Federal	Specialty drugs			√	√	√	√	√	√	√	√	√	√
TX	**Amino Acid-based Formulas**	Yes	Yes	√	√	√	√	√	√	√	√	√	√
TX	**Contraceptive Drugs and Devices and Related Services**	Yes	Yes	√	√	√	√	√	√	√	√	√	√
TX	**Off-label Drugs**	Yes	No	√	√	√	√	***$46.6 M - $85.9M***[23]	***$46.6 M - $85.9 M***	***$46.6 M - $85.9 M***	***$46.6 M - $85.9 M***	***$46.6 M - $85.9 M***	***$46.6 M - $85.9 M***
TX	**Oral Anticancer Medications**	Yes	Yes	√	√	√	√	√	√	√	√	√	√
TX	**Phenylketonuria (PKU)**	No	Yes	√	√	√	√	√	√	√	√	√	√
Federal	**(G) Rehabilitative and habilitative services and devices**												
Federal	Outpatient rehabilitation services			√[24]	√[24]	√[25]	√[26]	√[27]	√	√[28]	√[29]	√[30]	√[31]
Federal	Habilitation services			√[44]	√[44]	32	√[46]	33, 34	√[35, 44]	33, 35, 44	36, 33	36, 33	37
Federal	Durable medical equipment			√	√	√	√	√	√	√	√	√	√
TX	**Brain Injury - Acquired brain injury**	Yes	Yes	√	√	√	√	√	√	√	***$20.1 M - $56.8 M***[38]	***$20.1 M - $56.8 M***[38]	***$20.1 M - $56.8 M***[38]
TX	**Prosthetic / Orthotic Devices**	Yes	Yes	√	√	√	√	√	√	√	√	√	√
TX	***Speech and Hearing***	No	Offer	√	√	√	***$0***	√	√	√	√	√	***$0***[39]
	Outpatient Physical Therapy[22]			35 visits across physical medicine services	35 visits across physical medicine services	20 visits	20 visits across PT, OT, MT	No limit	No limit	20 visits / condition	75 visits across PT, OT, and ST[36]	50 visits across PT, OT, and ST[36]	60 visits across PT and OT
	Outpatient Occupational Therapy[22]					20 visits		No limit[34]	No limit[44]	20 visits[44] /condition			
	Outpatient Speech Therapy[22]					20 visits	20 visits	No limit	No limit	60 visits			30 visits

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Federal	**(H) Laboratory Services**												
	Diagnostic test (x-ray and lab work)			√	√	√	√	√	√	√	√	√	√
	Imaging (CT / PET scans, MRIs)			√	√	√	√	√	√	√	√	√	√
Federal	**(I) Preventive and wellness services and chronic disease management**												
	Preventive care / screening / immunization			√	√	√	√	√	√	√	√	√	√
TX	**Cardiovascular Disease - Screening Tests**	Yes	Yes	√	√	√	√	√	√	√	√	√	√
	Colorectal Cancer Testing	Yes	No	√	√	√	√	√	√	√	√	√	√
	Diabetes	Yes	No	√	√	√	√	√	√	√	√	√	√
	Osteoporosis, Detection and Prevention	No	Yes	√	√	√	√	√	√	√	√	√	√
	Prostate Testing - Coverage of Certain Tests	Yes	No	√	√	√	√	√	√	√	√	√	√
	Human Papillomavirus and Cervical Cancer Testing	Yes	Yes	√	√	√	√	√	√	√	√	√	√
	Mammography	Yes	Yes	√	√	√	√	√	√	√	√	√	√
Federal	**(J) Pediatric services, including oral and vision care**												
	Routine eye exam for children			√[40]	√[40]	√	√	√	√	√	√	√	√
	Eye glasses for children												
	Dental check-up for children										√[41]	√[41]	√[41]
TX	**Autism Spectrum Disorder**	No	Yes	√	√	√	√	***$3.1 M - $30.7 M***[42]	√	***$3.1 M - $30.7 M***[42]	***$3.1 M - $30.7 M***[42]	***$3.1 M - $30.7 M***[42]	***$3.1 M - $30.7 M***[43]
	Developmental Delays	Offer	No	***$0***[44]	***$0***[44]	***$0***[45]	***$0***[46]	***$0***[47]	***$0***[44]	***$0***[44]	***$0***[45]	***$0***[45]	***$0***[43]
	Hearing Screening	Yes	No	√	√	√	√	√	√	√	√	√	√
	Immunizations	Yes	No	√	√	√	√	√	√	√	√	√	√
	Reconstructive Surgery for Craniofacial Abnormalities in a Child	Yes	No	√	√	√	√	√	√	√	√	√	√

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Federal	**Supplementary Benefits Listed in HHS EHB Data Collection Template**												
Federal	Non-emergency care when traveling outside the U.S.			√	√		√	√	√	√	√	√	√
Federal	Routine dental services										√	√	√
Federal	Infertility treatment			√[48]	√[48]	√[49]	√[50]	√[51]	√[52]	√[52]	√[53]	√[53]	√[54]
Federal	Long-term / custodial nursing home care												
Federal	Private-duty nursing							√[55]					
Federal	Routine eye exam (adult)			√[40]	√[40]	√[56]	√	√[57]	√[58]	√[59]	60	60	61
Federal	Bariatric surgery							√[62]	√[63]	√	√[64]	√[64]	√[65]
Federal	Cosmetic surgery			66	66	67	68	69	70	71	72	72	73
Federal	Chiropractic care			√[24]	√[24]	√[19]	√	√[74]	√[75]	√[76]	√[77]	√[78]	√[79]
Federal	Hearing aids			√[80]	√[80]	√[81]		√[82]	√[83]	√[84]	√[85]	√[85]	√[86]
Federal	Routine foot care			87	87	88	89	90	91	92	93	93	93
Federal	Acupuncture					√[19]	94				√[95]	√	√[19]
Federal	Weight loss programs												

[1] Federal coverages are those that are included on the Summary of Benefits and Coverage (highlighted in grey) as well as the additional benefits listed on HHS' EHB Data Collection Template. There is no requirement that all federal coverages be included in the selected benchmark plan. Federal law does require that the selected benchmark plan include coverage for all 10 (A through J) categories. However, no guidance or definitions have been provided to assist state determinations of whether a category is covered or must be supplemented.

[2] A plan that shows a mandated benefit or offer as not covered should not be interpreted as not in compliance – not all mandates apply to all types of plans. For the purpose of this chart, state mandated offers are treated as mandated benefits; however, they must be interpreted differently. If the plan was required to offer a benefit, and the benefit is shown as not covered under the plan, this means the offer of coverage was not purchased within the largest plan. Although we identify non-covered mandated offers in red, unlike mandated benefits, we do not believe non covered mandated offers will impose a cost to the state.

[3] This number reflects the enrollment within TRS ActiveCare plan 2, which is the largest "portal plan" for the TRS Activecare PPO product. Across all four TRS ActiveCare PPO plans enrollment totals 440,104. TRS ActiveCare PPO plans are differentiated by cost sharing structures, but identical in benefits.

[4] Estimated costs assume that mandated offers do not impose a cost to the state. It is unknown whether the cost to the state would apply only for the enrollment in the Exchange, or for enrollment in all QHPs in and out of the Exchange. The range of estimated costs provided reflects this uncertainty.

[5] Subject to 60 visit annual limit

[6] Subject to 120 visit annual limit

[7] Subject to 25 visit annual limit

[8] Subject to 50 visit annual limit
[9] Subject to 180 visit annual limit
[10] Subject to 14 day annual limit
[11] Subject to $18,000 lifetime limit
[12] Subject to $15,000 limit and six month durational limit
[13] Subject to 20 visit outpatient limit. Limit combined for outpatient mental health services and outpatient substance use services
[14] Limits do not apply to Mental Health - Serious Mental Illness and for groups with 51 or more total employees
[15] Subject to 30 day annual limit; note, this limit does not apply to serious mental illness
[16] Subject to 20 visit annual limit; note, this limit does not apply to serious mental illness
[17] Subject to 10 day annual limit
[18] Subject to 15 day annual limit. Limit combined for inpatient mental health services and inpatient substance use services
[19] Subject to 20 visit annual limit
[20] Subject to 3 series lifetime limit
[21] Subject to 30 day annual limit
[22] At the request of interested stakeholders, this benefit was added to the analysis; as with other benefits, a checkmark indicate coverage under the plan, while a shaded cell indicates the benefit is not covered
[23] Not all prescription drug claims are reviewed to ensure use for FDA approved indications
[24] Subject to 35 visit annual limit across physical medicine services
[25] Subject to 20 visit annual limit for manipulative treatment and physical, occupational, speech, and pulmonary rehabilitation therapy; subject to 36 visit annual limit for cardiac rehabilitation therapy and post-cochlear implant aural therapy
[26] Physical and occupational therapy and spinal manipulation subject to combined 20 visit annual limit; speech therapy subject to separate 20 visit annual limit
[27] Occupational therapy limited to physical therapy modalities
[28] Physical therapy is subject to a 20 visit annual limit per condition; occupational therapy is subject to a 20 visit annual limit per condition
[29] Subject to 75 visit annual limit across all physical, occupational, and speech therapy; no apparent limit for cognitive rehabilitation therapy
[30] Subject to 50 visit annual limit across all physical, occupational, and speech therapy; no apparent limit for cognitive rehabilitation therapy
[31] Physical and occupational therapy limited to therapy to restore bodily function due to illness or injury and subject to a 60 visit annual limit; speech therapy subject to a 30 visit annual limit; long-term rehabilitation is not covered
[32] Determination of coverage updated to reflect UHC submission to HHS
[33] Applied behavior analysis (ABA) and educational therapies are excluded
[34] Occupational therapy services that do not consist of traditional physical therapy modalities as defined by the claims administrator are excluded
[35] Covered services must be medically necessary and meet or exceed treatment goals for a participant. For a physically disabled person, treatment goals may include maintenance of function or prevention or slowing of further deterioration.
[36] Maintenance or palliative rehabilitative therapy is excluded
[37] Physical and occupational therapy limited to therapy to restore bodily function due to illness or injury; long-term rehabilitation is not covered
[38] Biofeedback excluded
[39] Speech therapy (limited to 30 visits annually) is covered less favorably than physical medicine services (physical and occupational therapy are limited to 60 visits)
[40] Limited to one routine eye exam per year
[41] Subject to 2 visit annual limit
[42] Applied behavior analysis excluded
[43] Physical and occupational therapies covered only when there has been a total or partial loss of bodily function due to illness or injury; educational therapies and treatment for learning disabilities and mental retardation are excluded
[44] Occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of a rehabilitation program designed to restore lost or impaired body function are excluded
[45] Treatment for learning disabilities and mental retardation excluded; educational therapies excluded
[46] Occupational therapy excludes services designed to develop physical function; speech therapy excludes treatment of delays in speech development; services, treatment, and educational testing and training related to learning disabilities and delays in developing skills are excluded

[47] Educational services, e.g., services provided to address a participant's developmental delays, are excluded

[48] Diagnosis covered but treatment not covered unless a rider is purchased to cover In-vitro ONLY. NOT artificial Insemination.

[49] Health services and associated expenses for infertility treatments, including assisted reproductive technology, are excluded, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Please note: UHC's HIOS submission reflects that infertility is not covered. We are showing infertility as covered for the purpose of consistency, because it appears to provide the same level of coverage offered by the other benchmark plan options.

[50] The diagnosis and treatment of the underlying medical cause of infertility is covered. Services to enhance fertility, such as infertility medications, artificial insemination, in vitro fertilization, etc. are excluded.

[51] Participants (male and female) are eligible for infertility services which may include diagnostic laboratory and x-ray procedures, therapeutic injections and surgical treatment necessary for diagnosis and treatment of involuntary infertility subject to the same Deductibles, Coinsurance amounts, limitations and exclusions, and any other applicable Plan provisions. Covered services do not include sterilization reversal, transsexual surgery, gender reassignment, artificial insemination and related services, intra-fallopian transfer, or in vitro fertilization. Also excluded from coverage are any services or supplies used in any procedures performed in preparation for or immediately after any of the above referenced excluded procedures.

[52] Testing for problems of infertility is covered. Services or supplies provided for, in preparation for, or in conjunction with: sterilization reversal (male or female); transsexual surgery; sexual dysfunction, in vitro fertilization; or promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, transuterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte state transfer, zygote intra-fallopian transfer, and tubal embryo transfer are excluded.

[53] Diagnosis and treatment of infertility is covered, except for the following: assisted reproductive technology (ART) procedures, including but not limited to artificial insemination, in vitro fertilization, embryo transfer and gamete intrafallopian transfer, zygote intrafallopian transfer, intravaginal insemination, intracervical insemination, intracytoplasmic sperm injection, intrauterine insemination, services and supplies related to ART procedures, such as sperm banking, and infertility drugs used in conjunction with ART procedures.

[54] Diagnosis and treatment of infertility is covered, except for the following: infertility services after voluntary sterilizations, fertility drugs, genetic counseling and genetic screening, preimplantation genetic diagnosis, assisted reproductive technology (ART) procedures, such as: artificial insemination, in vitro fertilization, embryo transfer and gamete intrafallopian transfer, intravaginal insemination, intracervical insemination, intrauterine insemination, services and supplies related to ART procedures, cost of donor sperm, cost of donor egg

[55] Private-duty nursing charges are eligible for benefits only for that portion of time for which such level of skill is medically necessary. Examples of private-duty nursing services not covered are those simply for the convenience of the patient of patient's family or those consisting primarily of such acts as bathing, feeding, mobilizing, exercising, homemaking, giving medication, or acting as a companion or sitter.

[56] Limited to one routine eye exam every two years. Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

[57] Limited to one routine eye exam per year. A routine exam includes external examination of the eye and its structure, determination of refractive status, and a glaucoma screening test. It does not include a contact lens exam.

[58] Limited to one routine eye exam per year. Vision services or supplies, including but not limited to, orthoptics, vision training, vision therapy, radial keratotomy, contact lenses or the fitting of contact lenses, eyeglasses, photoreflective keratotomy, INTACS and LASIK are excluded.

[59] Excluded are any services or supplies provided for the correction of vision deficiencies, including but not limited to, orthoptics, vision training, vision therapy, radial keratotomy, eye refraction, photoreflective keratotomy, LASIK, contact lenses, eyeglasses or the fitting of contact lenses, except if a patient has a history of having had cataract surgery.

[60] Routine eye exams are not covered unless the exam relates to a specific medical condition. Except for accidental ocular injuries, amblyopia, and strabismus, eye glasses, contact lenses, and exams to determine the prescription are not covered.

[61] Vision services are limited to contact lenses or standard ocular implant lenses if required to correct an impairment existing after intraocular surgery or accidental injury, and vision therapy visits.

[62] Must be specifically authorized by the Plan Administrator in accordance with the bariatric surgery plan adopted by ERS and any rules adopted in accordance with TIC §1551.225. Benefits available only to eligible Employees as defined in TIC §1551.101 and no other Participants.

[63] Limited to medically necessary bariatric procedures performed at designated facilities.

[64] Bariatric surgery coverage is limited to participants that meet several requirements and is subject to prior approval

[65] Bariatric surgery coverage is limited to procedures performed at designated facilities for participants that meet several requirements. Bariatric surgery must be precertified.

[66] Covered only for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases. Please Note: BCBSTX's HIOS submission reflects that cosmetic surgery is covered. We are showing it as not covered for the purpose of consistency, as it appears to limit cosmetic surgery coverage to medically necessary reconstructive procedures, consistent with other benchmark plan options.

[67] Reconstructive procedures associated with an injury, sickness, or congenital anomaly are covered to treat a medical condition or to improve or restore physiologic function. Cosmetic procedures are excluded.

[68] Cosmetic services and plastic surgery are generally excluded, however reconstructive or cosmetic surgery is covered for the following medically necessary purposes: surgery to correct the result of an accidental injury; surgical implantation or attachment of covered prosthetic devices; surgery to correct a gross anatomical defect present at birth if the purpose of the surgery is to improve function, or for children up to age 18 to improve function or create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease; other surgery needed for the treatment of an illness in order to improve function, and breast reconstruction following a mastectomy.

[69] Cosmetic, Reconstructive, or Plastic Surgery is generally excluded, but is not excluded for children under 19 to treat or correct a congenital defect, treatment to correct defects incurred in an accidental or unexpected injury sustained while covered under the plan, treatment following cancer surgery, or treatment following a medically necessary mastectomy.

[70] Cosmetic, reconstructive, or plastic surgery is generally excluded, but is not excluded for medically necessary treatment for correction of defects due to accidental injuries that occur while covered by TRS-ActiveCare, reconstructive surgery following cancer surgery, treatment and surgery to correct a congenital defect in a newborn, surgery to correct a congenital defect in a child under 19, breast reconstruction following mastectomy, reconstructive surgery on a child under 19 due to craniofacial abnormalities, or reduction mammoplasty.

[71] Cosmetic, reconstructive, or plastic surgery is generally excluded, but is not excluded for medically necessary treatment for correction of defects due to accidental injuries that occur while covered by UT Select, reconstructive surgery following cancer surgery, treatment and surgery to correct a congenital defect in a newborn, surgery to correct a congenital defect in a child under 26 if the child has been covered since birth under a health plan offered by UT System, and breast reconstruction following mastectomy.

[72] Cosmetic surgery is excluded unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of an accidental injury, disease, or surgery (not including anomalies related to the teeth or structure supporting the teeth). Breast reconstruction following a mastectomy is also covered.

[73] Cosmetic surgery is generally excluded; however, reconstructive surgery is covered to correct a functional defect, to correct a condition caused by injury or illness if the condition produced a major effect on the participant's appearance and can reasonably be expected to be corrected by the surgery, to correct a condition that existed at or from birth and is a significant deviation from the common form or norm (limited to children under 18 unless there is a functional deficit), and breast reconstruction following mastectomy.

[74] Subject to a 30 visit annual limit.

[75] Subject to 35 visit annual limit

[76] Subject to a combined 20 visit annual limit per condition for physical therapy and chiropractic care

[77] Subject to an annual limit of to one office visit, one set of x-rays, and 12 manipulative treatment visits

[78] Subject to an annual limit of to one office visit, one set of x-rays, and 20 manipulative treatment visits

[79] Subject to 12 visit annual limit; includes coverage for x-rays used to detect and determine nerve interferences due to spinal subluxations or misalignments

[80] Hearing aids are covered up to a limit of $1,000 per 36 month period

[81] Hearing aids are covered up to a limit of $2,500 per year; benefits are limited to a single purchase (including repair/replacement) every three years. Bone anchored hearing aids are excluded unless certain criteria exist.

[82] Hearing aids are covered without application of any deductible up to a limit of $500 per ear for any consecutive three year period. The cost of hearing aid device replacement batteries is exempt from the benefit limit.

[83] Hearing aids are covered up to a limit of $1,000 per 36 month period. Hearing aids must be paid for in advance and claims for covered expenses must be submitted for reimbursement. Replacement for loss, damage, or functional defect is not covered, nor is repair or batteries.

[84] Hearing aids are covered without application of any deductible up to a limit of $500 per ear, once every four years. Hearing aid repair and batteries are not covered.

[85] Hearing aids are covered up to $1,250 per hearing aid per ear (including dispensing fees, accessories, supplies, and repair services) for hearing aids and bone anchored hearing aids for children and adults. Limit applies per calendar year for children under 22 and per 36 month period for adults 22 and older. Deductibles do not apply to the coverage for hearing aids.

[86] External hearing aids are covered up to $500 per ear per five year period. Deductible does not apply. Implanted hearing related devices, such as bone anchored hearing aids and cochlear implants are covered with coinsurance.

[87] Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency are excluded. Foot care in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency is covered. Please note: BCBSTX's HIOS submission reflects that Routine Foot Care is covered. We are showing it as not covered for the purpose of consistency, as it appears to be covered only for the treatment of diabetes and related disorders, consistent with the coverage provided in other benchmark plan options.

[88] Non-diabetic foot care is not covered. Routine foot care, such as the cutting or removal of corns and calluses, or hygienic and preventive maintenance foot care is excluded; this exclusion does not apply to preventive foot care for persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

[89] Routine foot care is excluded except as specifically covered for diabetics.

[90] Routine foot care is excluded. However, medically necessary diabetes equipment, diabetes supplies, or other services or supplies used for the treatment of circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency related to the treatment of diabetes are not considered routine foot care, and are covered.

[91] Routine foot care is excluded in the absence of severe systemic disease. Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes is covered.

[92] Foot care is covered in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes.

[93] Routine foot care is generally excluded, but is covered for participants under active treatment for a metabolic or peripheral vascular disease, such as diabetes.

[94] Acupuncture is excluded, except as a form of anesthesia in connection with a covered surgical procedure.

[95] Subject to 24 visit annual limit